Complete Summary

GUIDELINE TITLE

Pelvic pain in gynaecological practice. In: Guidelines on chronic pelvic pain.

BIBLIOGRAPHIC SOURCE(S)

Pelvic pain in gynaecological practice. In: Fall M, Baranowski AP, Elneil S, Engeler D, Hughes J, Messelink EJ, Oberpenning F, Williams AC. Guidelines on chronic pelvic pain. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. p. 62-5. [14 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Female chronic pelvic pain

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Obstetrics and Gynecology
Surgery
Urology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To help urologists in the clinical decisions they make every day
- To provide access to the best contemporaneous consensus view on the most appropriate management currently available

TARGET POPULATION

Women with chronic pelvic pain

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation

1. Medical history
2. Clinical examination
    - Abdominal and pelvic examination
3. Investigations
    - Vaginal and endocervical swabs
    - Cervical cytology screening
    - Pelvic ultrasound
    - Laparoscopy

Management/Treatment

1. Analgesics
2. Non-steroidal anti-inflammatory drugs (NSAIDs)
3. Oral contraceptives
4. Organism-specific treatment for infections
5. Luteinizing hormone releasing hormone analogues
6. Surgery

MAJOR OUTCOMES CONSIDERED

- Pain relief
- Side effects of medical treatments
- Surgical complications

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

A structured literature search was performed but this search was limited to randomized controlled trials and meta-analyses, covering at least the past three years, or up until the date of the latest text update if this exceeds the three-year period. Other excellent sources to include were other high-level evidence, Cochrane review and available high-quality guidelines produced by other expert groups or organizations. If there were no high-level data available, the only option was to include lower-level data. The choice of literature was guided by the expertise and knowledge of the Guidelines Working Group.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1a Evidence obtained from meta-analysis of randomized trials

1b Evidence obtained from at least one randomized trial

2a Evidence obtained from one well-designed controlled study without randomization

2b Evidence obtained from at least one other type of well-designed quasi-experimental study

3 Evidence obtained from well-designed non-experimental studies, such as comparative studies, correlation studies and case reports

4 Evidence obtained from expert committee reports or opinions or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

- The first step in the European Association of Urology (EAU) guidelines procedure is to define the main topic.
- The second step is to establish a working group. The working groups comprise about 4 to 8 members, from several countries. Most of the working group members are academic urologists with a special interest in the topic. Specialists from other medical fields (pain medicine, psychology, radiotherapy, oncology, gynaecology, anaesthesiology, etc.) are included as full members of the working groups as needed. In general, general practitioners or patient representatives are not part of the working groups. Each member is appointed for a four-year period, renewable once. A chairman leads each group.
- The third step is to collect and evaluate the underlying evidence from the published literature.
- The fourth step is to structure and present the information. All main recommendations are summarized in boxes and the strength of the recommendation is clearly marked in three grades (A-C), depending on the evidence source upon which the recommendation is based. Every possible effort is made to make the linkage between the level of evidence and grade of recommendation as transparent as possible.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendation

A. Based on clinical studies of good quality and consistency addressing the specific recommendations and including at least one randomized trial
B. Based on well-conducted clinical studies, but without randomized clinical studies
C. Made despite the absence of directly applicable clinical studies of good quality

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The Appraisal of Guidelines for Research and Evaluation (AGREE) instrument was used to analyse and assess a range of specific attributes contributing to the validity of a specific clinical guideline. The AGREE instrument, to be used by two

to four appraisers, was developed by the AGREE collaboration (www.agreecollaboration.org) using referenced sources for the evaluation of specific guidelines. (See the "Availability of Companion Documents" field for further methodology information).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Clinical History

It is essential to start by taking a detailed medical history. The nature, frequency and site of the pain, and its relationship to precipitating factors and the menstrual cycle, may provide vital clues to the aetiology. A detailed menstrual and sexual history, including any history of sexually transmitted diseases and vaginal discharge is mandatory. Tactful inquiry about previous sexual trauma may be appropriate.

Clinical Examination

Abdominal and pelvic examination will exclude any gross pelvic pathology (tumours, scarring and reduced uterine mobility), as well as demonstrating the site of tenderness if present. Abnormalities in muscle function should also be sought.

Investigations

Vaginal and endocervical swabs to exclude infection are mandatory and cervical cytology screening is advisable. Pelvic ultrasound scanning provides further information about pelvic anatomy and pathology. Laparoscopy is the most useful invasive investigation to exclude gynaecological pathology and to assist in the differential diagnosis.

Dysmenorrhoea

Primary dysmenorrhoea classically begins at the onset of ovulatory menstrual cycles and tends to decrease following childbirth. Explanation and reassurance may be helpful, together with the use of simple analgesics progressing to the use of non-steroidal anti-inflammatory drugs (NSAIDs), which are particularly helpful if they are started before the onset of menstruation. NSAIDs are effective in dysmenorrhoea probably because of their effects on prostaglandin synthetase. Suppression of ovulation using the oral contraceptive pill reduces dysmenorrhoea dramatically in most cases and may be used as a therapeutic test. Because of the chronic nature of the condition, potentially addictive analgesics should be avoided.

Secondary dysmenorrhoea suggests the development of a pathological process and it is essential to exclude endometriosis and pelvic infection.

Infection

A history of possible exposure to infection should be sought and it is mandatory in all cases to obtain swabs to exclude chlamydia and gonorrhoea, as well as vaginal and genital tract pathogens. Patient's sexual contacts need to be traced in all cases with a positive culture. If there is any doubt about the diagnosis, laparoscopy may be very helpful.

Primary herpes simplex infection may present with severe pain, associated with an ulcerating lesion and inflammation, which may lead to urinary retention. Hospitalization and opiates may be needed to achieve adequate analgesia.

Treatment

Treatment of infection depends on the causative organisms. Subclinical chlamydial infection may lead to tubal pathology. Screening for this organism in sexually active young women may reduce the incidence of subsequent subfertility.

Endometriosis

The condition may be suspected from a history of secondary dysmenorrhoea and often dyspareunia, as well as the finding of scarring in the vaginal fornices on vaginal examination, with reduced uterine mobility and adnexal masses. Laparoscopy is the most useful diagnostic tool.

Endometriotic lesions affecting the urinary bladder or causing ureteric obstructions can occur, as well as lesions affecting the bowel, which may lead to rectal bleeding in association with menstruation.

Treatment

As in primary dysmenorrhoea, analgesics and NSAIDs are helpful in easing pain at the time of menstruation. Hormone treatment with progestogens or the oral contraceptive pill may halt progress of endometriosis, but is not curative. A temporary respite may be obtained by using luteinizing hormone releasing hormone (LHRH) analogues to create an artificial menopause, though the resulting oestrogen deficiency may have marked long-term side effects, such as reduced bone density and osteoporosis in those taking more than six months worth of treatment. These drugs are used prior to surgery to improve surgical outcome and reduce surgical complications.

Surgery for endometriosis is challenging and the extensive removal of all endometriotic lesions is essential. The best results are achieved laparoscopically, by highly trained and skilled laparoscopic surgeons, in specialist centres. A multidisciplinary team will be required for the treatment of extensive disease, including a pain management team.

The pain associated with endometriosis is often not proportionate to the extent of the condition and, even after extensive removal of the lesions and suppression of the condition, the pain may continue.

Gynaecological Malignancy

The spread of gynaecological malignancy of the cervix, uterine body or ovary will cause pelvic pain depending on the site of spread. Treatment is of the primary condition, but all physicians dealing with pelvic pain must be fully aware of the possibility of gynaecological malignancy.

Injuries Related to Childbirth

Tissue trauma and soft tissue injuries occurring at the time of childbirth may lead to chronic pelvic pain related to the site of injury. Dyspareunia is a common problem leading to long-term difficulties with intercourse and female sexual dysfunction. Denervation of the pelvic floor with re-innervation may also lead to dysfunction and pain. Hypo-oestrogenism, as a result of breast feeding, may also contribute to pelvic floor pain and dysfunction.

Post-menopausal oestrogen deficiency may lead to pain associated with intercourse, which will respond to hormone replacement therapy.

Conclusion

Once all the above conditions have been excluded, the gynaecologist may well be left with patients with unexplained pelvic pain. It is imperative to consider pain associated with the urinary and gastrointestinal tract at the same time. For example, patients with bladder pain quite often present with dyspareunia due to bladder base tenderness.

Previously, pelvic congestion has been cited as a course of pelvic pain of unknown aetiology, but this diagnosis is not universally recognised.

As previously stated in dealing with pelvic pain, the best results will be obtained from a multidisciplinary approach that considers all possible causes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Accurate diagnosis and evaluation of chronic pelvic pain in women to determine a remediable cause of pain
- Appropriate treatment and management of chronic pelvic pain in women
- Relief of suffering caused by chronic pelvic pain in women

- Reduced incidence of subfertility

POTENTIAL HARMS

A temporary respite may be obtained by using luteinizing hormone releasing hormone analogues to create an artificial menopause, though the resulting oestrogen deficiency may have marked long-term side effects, such as reduced bone density and osteoporosis in those taking more than six months worth of treatment.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The European Association of Urology (EAU) believes that producing validated best practice in the field of urology is a very powerful and efficient tool in improving patient care. It is, however, the expertise of the clinician which should determine the needs of their patients. Individual patients may require individualized approaches which take into account all circumstances and treatment decisions often have to be made on a case-by-case basis.
- There are some very clear limitations on the use of the EAU Guidelines. These guidelines are specifically aimed at helping the practising urologist and will thus be of limited use to other health care providers or third party payers. These are limitations which we have accepted, given that the aim is to cover all of Europe and that such non-clinical questions are best covered locally. Another limitation is that the texts have no medico-legal status, nor are they intended to be used as such.
- The purpose of this text is not to be proscriptive in the way a clinician should treat a patient but rather to provide access to the best contemporaneous consensus view on the most appropriate management currently available. EAU guidelines are not meant to be legal documents but are produced with the ultimate aim to help urologists with their day-to-day practice.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The European Association of Urology (EAU) Guidelines long version (containing all 19 guidelines) is reprinted annually in one book. Each text is dated. This means that if the latest edition of the book is read, one will know that this is the most updated version available. The same text is also made available on a CD (with hyperlinks to PubMed for most references) and posted on the EAU websites Uroweb and Urosource (www.uroweb.org/professional-resources/guidelines/ & http://www.urosource.com/diseases/).

Condensed pocket versions, containing mainly flow-charts and summaries, are also printed annually. All of these publications are distributed free of charge to all (more than 10,000) members of the Association. Abridged versions of the guidelines are published in European Urology as original papers. Furthermore, many important websites list links to the relevant EAU guidelines sections on the

association websites and all, or individual, guidelines have been translated to some 15 languages.

IMPLEMENTATION TOOLS

Pocket Guide/Reference Cards

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Pelvic pain in gynaecological practice. In: Fall M, Baranowski AP, Elneil S, Engeler D, Hughes J, Messelink EJ, Oberpenning F, Williams AC. Guidelines on chronic pelvic pain. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. p. 62-5. [14 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Mar

GUIDELINE DEVELOPER(S)

European Association of Urology - Medical Specialty Society

SOURCE(S) OF FUNDING

European Association of Urology

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All members of the Chronic Pelvic Pain guidelines writing panel have provided disclosure statements on all relationships that they have and that might be perceived as a potential source of conflict of interest. This information is kept on file in the European Association of Urology Central Office database. This guideline document was developed with the financial support of the European Association of Urology (EAU). No external sources of funding and support have been involved. The EAU is a non-profit organisation and funding is limited to administrative assistance, travel, and meeting expenses. No honoraria or other reimbursements have been provided.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the European Association of Urology Web site.

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- EAU guidelines office template. Arnhem, The Netherlands: European Association of Urology (EAU); 2007. 4 p.
- The European Association of Urology (EAU) guidelines methodology: a critical evaluation. Arnhem, The Netherlands: European Association of Urology (EAU); 18 p.

The following is also available:

- Guidelines on chronic pelvic pain. 2005, Ultra short pocket guidelines. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. 18 p.

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on December 29, 2008. The information was verified by the guideline developer on February 27, 2009.

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